

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 2 - 0 0 3

2. STATE:

GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

April 1, 2002

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440.200

7. FEDERAL BUDGET IMPACT:

a. FFY _____ \$ No Budget Impact

b. FFY _____ \$ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, p. 2h

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

attachment 3.1-A, p. 2h

10. SUBJECT OF AMENDMENT:

CORRECTING COVERAGE FOR OPTOMETRIC SERVICES

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Mark Trail

14. TITLE:

Director, Division of Medical Assistance

15. DATE SUBMITTED:

May 30, 2002

16. RETURN TO:

Department of Community Health
Division of Medical Assistance
2 Peachtree Street, N.W.
Atlanta, GA 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

June 4, 2002

18. DATE APPROVED:

August 12, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

April 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

Hugh L. Webster for Rhonda Cottrell

21. TYPED NAME:

Rhonda R. Cottrell

22. TITLE:

Associate Regional Administrator
Division of Medicaid

23. REMARKS:

6b. OPTOMETRIC SERVICES (continued)

Prior Approval is required on the following: (continued)

7. Ultraviolet tint for prosthetic lenses and/or goggles for retinitis pigmentosa, albinism, and aphakia.
8. Change of eyeglass prescription when the power of the axis is less than 5 degrees or a diopter change in sphere or cylinder power. New lenses must also improve visual acuity by at least one line on a standard acuity chart.
9. Oversized Frames (Flatter Fit)
10. Trifocal Lenses
11. Slab off lens(es)
12. Hi-index plastic lenses (for prescription of less than ± 6 diopters)
13. polycarbonate lenses

Non-Covered Services

1. Tinting lenses (except for albinism and retinitis pigmentosa)
2. Experimental services or procedures or those that are not recognized by the profession or the U. S. Public Health Services as universally accepted treatment.
3. Routine refractive services and optical devices provided for recipients twenty-one years of age or older.

TN No. 02-003

Supersedes

Approval Date

AUG 12 2002

Effective Date

APR 01 2002TN No. 92-033